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# Health Reform Policy Issues in Malawi: A Rapid Assessment

*July 1998*

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Partnerships  
for Health  
Reform

**PHR**



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Partnerships  
for Health  
Reform

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- ▲ *improved incentives within health financing systems to encourage agents to use and deliver efficient and quality health service; and*
- ▲ *improved organization and management of health care systems and institutions to support specific health sector reforms.*

*PHR advances knowledge and methodologies to develop, implement and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.*

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# Abstract

Malawi's health sector reform options include decentralization, targeted efforts such as central hospital autonomy, and the convergence of these efforts. A number of policy implications have emerged from these reform efforts. As a result, the Malawi Ministry of Health and Population (MOHP) requested the participation of the United States Agency for International Development in a rapid assessment of health reform policy. This assessment report serves both as a stand-alone document and as the basis for the development of a proposed workplan for the Partnerships for Health Reform (PHR) Project. Major policy issues and options for the near future include: managing change, training for reform, planning and implementation, consensus-building workshops, performance monitoring, and sector-wide approaches. Conclusions emphasize evolving roles for the MOHP in health reform advocacy, policy development, and communicating goals to districts, non-health government institutions, the public, and other constituencies.

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# Acronyms

<b>CBD</b>	Community Based Distribution
<b>CHAM</b>	Christian Health Association of Malawi
<b>CMS</b>	Central Medical Stores
<b>DDF</b>	District Development Fund
<b>DfID</b>	Department for International Development
<b>DHMT</b>	District Health Management Team
<b>DHO</b>	District Health Office(r)
<b>ESA</b>	East and Southern Africa
<b>EU</b>	European Union
<b>FHI</b>	Family Health International
<b>GOM</b>	Government of Malawi
<b>HPU</b>	Housing Planning Unit
<b>IDA</b>	International Drug Association
<b>IDA</b>	International Development Agency
<b>MASAF</b>	Malawi Social Action Fund
<b>MMAS</b>	Malawi Medical Aid Society
<b>MIS</b>	Management Information Systems
<b>MOA</b>	Memorandum of Agreement
<b>MOH</b>	Ministry of Health
<b>MOHP</b>	Ministry of Health and Population
<b>MOLG</b>	Ministry of Local Government
<b>MSI</b>	Management Systems International
<b>MTEF</b>	Medium Term Expenditure Framework
<b>NGO</b>	Non-governmental Organization
<b>NHP</b>	National Health Plan
<b>OPC</b>	Office of the President and Cabinet
<b>OPD</b>	Outpatient Departments
<b>ORT</b>	Other Recurrent Transactions

<b>PHR</b>	Partnerships for Health Reform
<b>REDSO</b>	Regional Economic Development Services Office
<b>SWAP</b>	Sector-wide Approach
<b>UK</b>	United Kingdom
<b>UN</b>	United Nations
<b>UNCDF</b>	UN Capital Development Fund
<b>UNDP</b>	UN Development Fund
<b>UNFPA</b>	UN Fund for Population Activities
<b>UNHCR</b>	UN High Commission on Refugees
<b>UNICEF</b>	United Nations' Children's Fund
<b>USAID</b>	United States Agency for International Development

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# Executive Summary

Malawi has been examining a range of health sector reform options. Many of these options have involved approaches to decentralization. Others focus on more targeted efforts such as autonomy for two central hospitals. Policy options arise from the convergence of these efforts in the course of developing the next five-year National Health Plan, implementation of a new district planning processes, and implementation of financial reforms such as the Medium Term Expenditure Framework and the Cash Management System.

This rapid assessment of health reform policy has been conducted by a United States Agency for International Development (USAID) team in response to an earlier request from Ministry of Health and Population (MOHP) officers. It both serves as a stand-alone document and as the basis for the development of a proposed workplan for a USAID contractor, Partnership for Health Reform (PHR). The team consists of a representative from USAID's Africa Bureau in Washington, an officer from USAID's regional health office in Nairobi, the Africa coordinator, and a PHR consultant. The MOHP Planning Unit served as counterpart for this effort.

Conclusions from this analysis emphasize evolving roles for the MOHP in health reform advocacy, in policy development, and in communicating goals and objectives to districts as well as non-health government institutions, the public, and other constituencies. Major policy issues and options for the near future include:

*Managing Change.* Decentralization, in particular, may be perceived as threatening to many. The process needs to be well-planned, predictable, and transparent. Communication of intended changes will better assure success.

*Training for Reform.* Success at each step in the reform process will require skills in analysis, implementation, and advocacy. The Ministry as a whole, and the Health Planning Unit in particular, will shift to a greater reliance on policy analysis, strategic planning, health care finance, and improved use of data for informed decision-making.

*Planning and Implementation.* Each step in the reform process should anticipate personnel and budgetary requirements, as well as the resulting lateral impact on other aspects of the health system. Constraints must be anticipated. Strategies must be developed to overcome these constraints.

*Consensus-Building Workshops.* These workshops will identify and discuss issues associated with the reform process. Competing interests and factions will be brought into the planning of a single agreed-upon plan for implementation.

*Performance Monitoring.* Common indicators will monitor and assess progress toward health reform and its impact on health status. Where monitoring indicates, corrective interventions will be initiated. The information will be shared with the larger constituency involved in the reform process.

*Sector-wide Approaches.* The government's role in managing donor assistance will be strengthened. This will result from reinforced financial accountability and management systems, improved capacity at the planning unit, refinement of the Management Information System, and continuing policy negotiations.

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# 01. The Reform Process

During the past decade, Malawi has examined reform options ranging from large scale, macro reforms such as decentralizing the health sector, to more modest changes such as integrating certain public health programs or making adjustments to the essential drug list. There has been movement on many of the more modest reforms; yet action to make substantial changes—those which significantly improve the efficiency, equity, or of the quality of health services—have not occurred. This is in part due to continuing economic constraints, changes in political systems, and, at times, lack of political will.

A number of current activities makes this a good time to look at opportunities for reform. These current activities include:

- ▲ Progress of a proposed government-wide decentralization proposal within the Office of the President and Cabinet (OPC);
- ▲ Discussion of a proposal to “autonomize” central hospitals;
- ▲ Development of the five-year National Health Plan;
- ▲ Design and implementation of a new district planning process, and
- ▲ Use of the Medium Term Expenditure Framework for public sector budgeting.

Although these activities suggest progress in health policy, each generates resistance to change. Such resistance, especially in the aggregate, could work against the larger goal of improving health status.

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## 1.1 Analysis

The health reform process involves the interests of various stakeholders no less than technical analysis. Any process that does not attend sufficiently to stakeholder interests risks producing unintended or unanticipated consequences. For example, a decentralization reform intended to reduce the staffing of a ministry of health instead increased such staffing (e.g., Uganda). Efforts to increase financial equity—such as tax breaks for those who pay insurance premiums—may result in subsidizing the rich. In addition, these reforms, including the ones identified above, are interconnected. One reform will affect another, often in unpredictable ways.

The implications of many of the reforms being considered in Malawi have not been adequately examined. The goals of reforms lack definition. Stakeholder concerns are not yet identified and addressed. The connection with other reforms/plans are not specified. Implementation steps are not been documented. Budget implications are not predicted. Often, the Ministry of Health and Population (MOHP) has fully identified the time required to achieve results. In many cases, a long period will be

required to build management capacity before there is a measurable impact on either health status or indicators of health system efficiency. This should not be used as a reason not to pursue or implement reforms.

The capacity to advocate for reforms within the MOHP needs to be strengthened. Advocacy skills are not common among health professionals. Other skills essential to the health reform process include strategic planning, effective communication of reform goals and priorities, and collaboration with non-health government institutions, the public, and other constituencies.

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## **1.2 Current Issues and Proposed Technical Interventions**

The following discussion documents current issues involved in the reform processes.

### **1.2.1 Current Issue: Decentralization**

A local government model of decentralization has been proposed. Whereas decentralization has been discussed in more general terms for many years, action on this specific proposal is likely this year. The proposed decentralization will involve significant effort and considerable complexity. The MOHP needs to manage this reform or, alternately, it will be overwhelmed by events. Under the proposed decentralization, every level of the health system, as well as individuals at that level, will have divergent views on this reform. Particular attention will be required so as to identify and resolve these differences of opinion.

### **1.2.2 Current Issue: Autonomy of Central Hospitals**

The MOHP leadership is particularly interested in establishing autonomous central hospital boards. Legislation will be required, as will the identification of implementation requirements. How this proposal will interact with decentralization and Medium Term Expenditure Framework (MTEF) reforms needs to be delineated. An examination of experience recommends attention should be given to identifying the interests of all stakeholders. This is particularly true given the magnitude of MOHP resources consumed by these hospitals. Attempts to reduce budget support may encounter opposition.

### **1.2.3 Current Issue: Five-Year National Health Plan**

The MOHP held a June 1998 planning retreat to establish the framework for the development of the National Health Plan (NHP). The NHP is to be completed by December 1998. The NHP process provides an opportunity for the MOHP to achieve several goals. These opportunities include:

- ▲ charting a course for the health sector for the next five years, a course which realistically identifies the various reform processes, how they interact, as well as public health goals and targets;

- ▲ involving the district and regional health teams in developing a common vision and informing all levels of the pending reform and its implications; and,
- ▲ involving communities, local government officials, and donors to better inform each of these groups about health issues.

#### **1.2.4 Current Issue: District Health Planning**

The *MSI Management Audit* (Marsh et al. 1997) reports that links between district health planning and local area planning have yet to occur. This is in part due to the lack of clear guidance and purpose for making this linkage. It may also reflect the unreliable flow of funds to districts. The MOHP has developed district planning guidelines. Whereas such planning can indeed be useful, its eventual success is predicated on two conditions: a) resource flows must become regular, and b) the districts must have increased autonomy and flexibility to program the funds in response to local needs.

#### **1.2.5 Current Issue: Medium Term Expenditure Framework**

The MOHP, as well as the government of Malawi (GOM), has been in the process of implementing the MTEF for the past two years. However, there have been a number of delays, and this year the MTEF was still not used to prepare the government's budget. However, MOHP units have been experimenting with reorganizing their budgets into the MTEF framework. This experience will prove valuable in the future.

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### **1.3 Proposed Technical Assistance**

This section suggests a number of options for technical assistance.

#### **1.3.1 Technical Assistance: Managing Change**

Given the number of changes currently under consideration, and given the likelihood that many of these changes may be undertaken concurrently, assistance should be provided to the MOHP in managing change. Managing change is necessary because many of these reforms, decentralization for example, may be perceived as threatening by many employees. Particular attention should be given to defining goals, identifying stakeholder interests, planning for resource allocation, budgeting, the development of implementation plans, and communicating with stakeholders.

#### **1.3.2 Technical Assistance: Training in the Reform Process**

Guiding and implementing reforms requires political understanding and change-agent skills. MOHP personnel are typically trained as health professionals and experienced in administering existing systems. The MOHP may therefore benefit from training them in change-agent skills and strategies. This would include analyzing options, defining the reform process and its identifying its components,

working with stakeholders to develop coalitions, developing and implementing an advocacy plan, communicating reforms to the community and government ministries, and understanding the needs and interests of politicians. Particular attention to the sequencing of reforms will be important for Malawi. Other key skills include recognizing the link between reforms, scheduling adequate time for implementation, and recognizing the political time frames which are centered around elections. Related to this task is the need for specialized training of MOHP personnel in policy analysis, health care finance, strategic planning, and use of Management Information Systems (MIS) data for reform. The Health Planning Unit will be empowered to provide many of these functions.

### **1.3.3 Technical Assistance: Planning and Implementation**

Implementation plans will be required for the “roll-out” of each reform. This includes identification of personnel and budgetary needs, as well as recognition of the possible effects of the reform on other aspects of the health system. In particular, implementation plans must note management capacity limitations and identify strategies for overcoming such constraints.

### **1.3.4 Technical Assistance: Consensus-Building Workshops**

The reform process involves many competing interests and factions. Support for consensus-building workshops will assist in identifying and discussing various issues associated with a new reform. In particular, consideration of implementation issues will be a priority.

### **1.3.5 Technical Assistance: Performance Monitoring**

There is an urgent need to identify and couple monitoring indicators to the implementation of reforms. Assistance can be provided in the development and refinement of such indicators, as well for the training in the use and sharing of this information. There is a critical need for continuous learning as reforms are undertaken. Implementation of reforms may inadvertently produce adverse outcomes, such as lowering of health status indicators. Such outcomes must be identified early and corrected. Other issues include monitoring the effects of reforms on: equity, the stated objectives of the reforms, interactions between different components of the health system, effects on clients, and relationships with donors.

### **1.3.6 Technical Assistance: Sector-wide Approaches**

Sector-wide Approaches (SWAPs) are increasingly discussed as a mechanism for donor-government collaboration. However, such a process places a high management burden on the MOHP as well as on the entire health care system. Whereas the Malawi MOHP may not be prepared now to undertake such a process, technical assistance can create the required management capacity. Technical assistance can reinforce: financial accountability and management systems, the Health Planning Unit's capacities, MIS capability, procurement and Central Medical Stores (CMS) capacity, policy negotiation, MTEF budget implementation, and decentralization. Additional assistance to the United

States Agency for International Development (USAID) mission will be necessary to conduct any necessary studies and to prepare USAID to coordinate the donor working group.



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## 02. Decentralization

The prospect of devolution occurring in the near future differentiates current activities from the more general discussions about decentralization over the past decade. If the OPC proposal is approved in the legislature, there will be an immediate need to address a number of issues affecting the health sector. There are a number of inter-related issues, but among the most pressing are:

- ▲ *Linkage to local government.* There is a divergence of approaches to decentralization. The MOHP has been pursuing a strategy of “*selective deconcentration*” whereby responsibility for certain functions have been delegated downwards. This includes, for example, authority over hiring of lower graded staff and management of recurrent budgets. The central MOHP, nevertheless, retains some control over these functions. For example, cash budgeting allocations restrict the freedom of action by the district health management teams (DHMT), and the firing of staff continues to require approval from the center. In contrast, the local government model proposed by OPC is more all-encompassing. Devolution in the OPC proposal includes district councils, district development funds (DDF), and staff delinkage. The difference between these approaches, and varying expectations of the line and central ministries, creates the risk of tension between ministries in the implementation of the reform. This could lead to confusion in the health sector, and commensurate inefficiencies.
- ▲ *Management capacity of DHMTs.* District level staff have not been adequately trained to take on extensive new management and planning responsibilities. For example, the district health officers (DHOs) are given 2–4 weeks of training in management and sent to the field. Fifteen district health administrators have been trained by the World Bank. Nevertheless, this is inadequate. Realistic and creative planning for increasing district management capacity needs to begin soon.
- ▲ *Future status of vertical programs.* The large number of vertical programs in the MOHP poses challenges for effective decentralization. The reorganization and integration of many of these programs will need to be addressed. Programmatic guidance must be retained at the central level. Efficiencies and duplication must be reduced; donors must coordinate support for the reorganization of vertical programs.
- ▲ *Linkage to the private sector.* There is poor communication and coordination between the public sector, the private non-profit sector, and for-profit sector. Although the DHMT’s are aware of the facilities of the Christian Health Association of Malawi (CHAM) and conduct supervisory visits, CHAM management is not invited to participate in DHMT meetings. MOHP documents do not include a role for the private sector (see Picazo and Marsh et al. 1997). Decentralization will require much greater coordination between the public and private sectors. This includes CHAM, private for-profit providers, MOLG clinics, and large employers such as tea or tobacco estates.
- ▲ *Financial decentralization.* DHMTs already manage their recurrent budget allocations. Approximately one-third (200 M Kw) of the public health sector budget continues to be

managed by the central MOHP. Much of this could be reallocated to other levels. This will entail a review across all health accounts to determine which programs should be restructured or unfunded (e.g., see Picazo 1998). It will also involve an examination of vertical program funding. Devolution must protect funding from being diverted to other purposes, such as diversions resulting from political directives. Reallocation of staff to lower levels will also affect financial allocations.

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## 2.1 Legislation from the Office of the President and Cabinet

A local government bill proposed by OPC's Department of District and Local Government Authority<sup>1</sup> is currently under consideration by the Cabinet. This bill would create and empower a single local government category by replacing separate existing legislation which defines authorities for three cities, 11 towns, and 26 districts. Under this proposed new legislation, *deconcentration* to the regional level would be replaced by *decentralization* or *devolution* to the district level. The legislation establishes district councils advised by health committees. The DHO will head the district health committee. Funds for health will flow directly from the Ministry of Finance/Treasury to the councils, bypassing the regions. Health funds will be *protected* or earmarked for health services. The regional role will be diminished, though one informant believes they will continue to provide technical assistance to the districts. One element of the legislation specific to the MOH would leave district and central hospitals as the responsibility of the Ministry while transferring health centers and health posts to local government authorities. All operating costs for health centers and health posts, including drugs and medical supplies, would be assumed by local government as soon as the legislation becomes law. Salaries for health center and health post staffing would only be transferred after approximately a two or three year period.

The United Nations Capital Development Fund (UNCDF) has piloted district development funds in six districts. These pilots began in 1994 and have been extended to nationwide coverage beginning in January 1998. By July 1998, each district will have been trained in planning and budgeting and will have its own DDF. The Ministry of Finance has assigned treasury cashiers at each district. Funds within the DDFs are coded by (1) sector, (2) donor, and (3) project; and are accounted for through this coding system. The central bank maintains individual accounts for each district and transfers from these accounts to district accounts in commercial banks in, or close to, each district. Currently, these funds move through the MOHP, but when and if the proposed legislation passes, funds will move directly to the districts. When no commercial bank is physically located within the district, already established satellite banking systems are used. Donor funds that pass through the DDF are typically released according to a Memorandum of Agreement (MOA) between the donor and the district. The MOA typically requires signature of the DHO for amounts up to 70,000 Kwacha (currently ~US\$ 3,000) plus additional signatures from the district commissioner for amounts in excess of 70,000 Kwacha. Funds are distributed to districts according to a formula negotiated with the GOM. This formula is based on five criteria: (1) equity, (2) geographical spread, (3) poverty needs, (4) population, and (5) response or absorption (similar to *pipeline*). Other donors involved in the DDF process include UNICEF, UNFPA, UNDP, and UNHCR. Participating non-governmental organizations (NGO)

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<sup>1</sup>Department of District and Local Government Administration within the Office of the President and Cabinet (OPC). This department was formerly the Ministry of Local Government (MOLG) before it decentralized itself into the Office of the President.

include Save the Children (UK), Project Hope, ActionAid, CHAM, the Malawi Social Action Fund (MASAF), and the Malawi Red Cross.

Much of the above process has been managed by a decentralization steering committee within OPC and dominated by central ministries. These groups have sponsored study tours to Ghana, the Philippines, Uganda, and Tanzania. Within this steering committee, each ministry has different concerns. OPC staff say the Ministry of Health is concerned about its ability to “communicate” priorities to the local authorities.

The assessment team conducted a site visit to one district (Salima) which was in the process of initiating the new system. Two members of the DHMT had undergone training during the previous week. The district commissioner described an extensive effort to gather community participation through village and traditional authorities. The DDF in Salima district had attracted participation from seven NGOs in addition to U.N. agencies and government offices.

Recommendation: USAID/Malawi should move limited funds through the DDF to determine the appropriateness of this decentralized funding mechanism for future USAID assistance strategies.

Recommendation: OPC staff referred to a University of Southern California course on capacity building for decentralization. This course should be investigated further. If it proves appropriate, USAID should sponsor MOHP officers to study at this course.

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## 2.2 Central MOHP Restructuring

A number of Malawian studies have discussed the need to restructure the central MOHP, both in light of decentralization, and in its absence. The MSI management audits have also discussed many of the issues at length. Site visits to districts reinforced many of the prior conclusions. Some of these observations are:

- ▲ inadequate articulation of MOHP responsibilities;
- ▲ poor coordination between responsibility nodes;
- ▲ an inadequate MIS/Health Information System (HIS) system;
- ▲ lack of definition regarding the relative roles of the MOHP headquarters, regional health offices, and districts in the future, and their relationship to one another; and,
- ▲ insufficient personnel to assure key functions such as health financing, planning, policy analysis, and legal frameworks.

The MOHP is in the process of developing a series of planning documents on human resource needs, the new national health plan, and health care financing. It is unclear whether, in the context of these planning exercises, the central MOHP expects to reorganize itself in anticipation of decentralization. Nevertheless, the central MOHP is involved in policymaking, standard setting, budget

determination, and cash management budgeting allocations; technical support for lower levels; and management of vertical programs. Under the local government (OPC) model of decentralization, the central MOHP will need to be reformed so as to be more responsive to the needs of the health sector (all levels), and to be more efficient.

**Recommendation:** USAID should support central MOHP restructuring efforts. This should be done in collaboration with the European Union (EU), the World Bank, the civil service commission and the OPC. USAID could provide assistance in developing the legal and regulatory framework to support restructuring.

**Recommendation:** Study tours should be scheduled to countries in the region that have undertaken transformation of their central MOHP. Possibilities include Uganda, Zambia, Ghana, and South Africa.

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## **2.3 The MOHP Health Planning Unit**

The Health Planning Unit (HPU) has an essential role in supporting decentralization, restructuring the budget, functioning of the HIS, and providing strategic guidance for the health sector. There have been a number of recent changes affecting the HPU. The health information systems have been transferred from CHSU back to the HPU. New staff have joined, although some do not have fixed posts. The HPU has assumed the lead role in developing district planning guidelines and the new national health plan. Nevertheless, further capacity-building is likely to be required at the HPU as decentralization and other events demand attention from this unit.

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## 03. Hospital Autonomy

The Hospital Autonomy Working Group estimated that only 10 percent of the health budget is spent on level II and level III hospital care (i.e., hospitals using specialists and sub-specialists) but that, overall, 50 percent of the total health budget is channeled through hospitals (MOHP, July 1997) and as much as 30 percent (Picazo 1997) is accounted for by the three Central Hospitals (Lilongwe Central Hospital, Queen Elizabeth Central Hospital in Blantyre, and Zomba Central Hospital). The same report concludes there is little scope of reducing the hospital share of the budget from the present levels. Most facilities are already under-resourced and under-staffed. Proposals to make the three central hospitals autonomous are not linked to either a Malawi Health Sector Strategic Plan or to a National Health Care Financing Plan. The MTEF is based on the assumption that current levels of public financing of hospital services will be maintained *and* that all hospitals will have at least the minimum number of staff (MOHP August 1997a). The PSIP anticipates new district hospital facilities providing an additional 1,500 beds as well as the new Mzuzu Central Hospital. This expansion of district hospitals represents a 27 percent increase in acute care beds compared with 1996/97. A decrease in MOHP resources for curative care, either in absolute or relative terms, is unlikely. The purpose of establishing autonomous hospitals is to increase the authority of the hospital boards. Management would be allowed to make their own decisions thereby increasing efficiency and improving the quality of services.

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### 3.1 Constraints

Achieving such objectives is largely dependent on improvements in management skills. All public hospitals face resource shortages. They also have limited managerial capacity. This affects patient management, standards of care, and the effectiveness of the administrative and support services. In particular, there is limited capacity to introduce effective financial planning and budgeting, and to improve financial control and accountability. Limited resources are not being used effectively and efficiently. Purchasing and supplies management, control over assets, and maintenance of equipment and facilities are all areas requiring improved management.

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### 3.2 Strategies

Hospital facilities account for almost two-thirds of the government recurrent health expenditure<sup>2</sup> and most facilities have ineffective organizational structures and management systems. Improved efficiency and the generation of additional revenue are strategies to prevent an increase in the hospital share of the total budget. User fees are not expected to be broadly in place until three or four years after the introduction of central hospital autonomy. Financial sustainability in the short term will continue to be problematic.

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<sup>2</sup>Table 2.8, Allocation of government recurrent health expenditure 1996/97, in MOHP, August 1997a.

The introduction of fees at central hospitals for all patients who can afford to pay—not just those in private wards—is an essential requirement for functional autonomy. This was emphasized in the recent study tour to Kenya. Provincial hospitals scheduled for autonomous status in Kenya are meeting 50 percent of their non-pay recurrent costs with user fees. Although these fees may be subject to some seasonal variations, they nevertheless provide a reliable source of income. All earnings are retained by these hospitals. Earnings provide the financing required to improve infrastructure and equipment and reward good performance. Still, the MOHP in Malawi is reluctant to introduce new cost sharing measures until hospitals can implement them properly, and until services improve to a level at which the public perceives it is getting value for money.

Structural changes may prove easier than improvements in decision-making and management capacities. A substantial investment in management capacity at the central MOHP will be required. Training for hospital staff will be needed in the following key areas:

- ▲ general management
- ▲ financial management
- ▲ human resources management
- ▲ purchasing and supplies management
- ▲ management information systems

A March 1997 report proposed feasibility studies for the three hospitals. These studies would cover the policy framework and legal status, specified services, organization, management and staffing, and financing. The studies would also identify opportunities for broadening the revenue base, improving efficiency, and containing cost. The studies could be contracted out.

**Recommendation:** A management audit should be conducted at the three central hospitals. This audit will propose interventions to improve financial sustainability. The audit will follow on the work of the Health Finance Working Group and the Hospital Autonomy Working Group. A long-term health financing plan will be developed for the three central hospitals.

**Recommendation:** A program of activities should be developed which will ensure the three central hospitals acquire necessary management skills. Benchmarks should be used for performance evaluation and to support a corresponding incentive system.

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### **3.3 Implementation**

An implementation plan will ensure all three central hospitals realize the benefits of increased autonomy. The plan will make the hospitals more accountable by requiring them to adopt performance evaluation supported by management accounting systems. The hospitals will need to focus on improved management of resources. Quality and patient satisfaction need to be given prominence. Costs must be measured by the new systems and operational efficiency should be improved.

Implementing hospital autonomy is a political as well as a technical process. The government's objectives imply a gradual process. Financial and organizational autonomy will be granted to the central hospitals over a number of years and will be limited by the need to ensure that there is appropriate regulation, control and accountability.<sup>3</sup> There is, however, an opportunity now to begin communicating the need for change, consensus building, management restructuring and installation of new management systems, particularly new financial management systems.

Recommendation: The capital development plan should emphasize investments which support “cost plus” pricing for private services and strengthen the private patient user fee system. This will subsidize those patients least able to pay.

Recommendation: Comprehensive business planning at hospitals should incorporate all revenue sources. Arrangements for insured patients and options for full cost recovery should be considered. Payment mechanisms by insurers and options for service contracts with employers should be reviewed.

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### **3.4 Financial Management System**

The Hospital Autonomy Working Group recognizes that a phased approach will be necessary. Hospitals will be given authorities as they demonstrate prerequisite capacities. For example, it may be some time before the hospital takes full control over personnel functions such hiring and firing, creation of new posts, negotiating conditions of service, and managing the payroll and pension funds. This level of management will require improved financial accounting and cost accounting; cash collection/invoicing and billing; purchasing and supplies management; inventory control (particularly pharmacy management and drug control); patient accounting, administration, and management systems; and personnel management systems. Each of these systems is linked and may require the establishment of new departments. Short-term technical assistance may be required during the early stages of implementation. The finance department, in particular, may need additional staff to manage new functions. Such functions will include financial planning and budgeting, departmental and specialty costing, and improved financial reporting. Computer-based financial accounting systems will improve hospital operational efficiency. Implementation will require careful planning. This can be done in stages with each stage introducing increased integration and new levels of management controls. A program of system development and implementation is outlined in Annex A.

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### **3.5 The Purchaser-Provider Split**

The central MOHP will be responsible for determining national standards and guidelines for hospitals, the regulation of hospitals, and such matters as conditions of service, staff salary scales, and setting policy on user charges and fees. The system of resource allocation and performance monitoring of hospitals depends on a contract negotiated between the MOHP as purchaser, and the hospital as

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<sup>3</sup>USAID/Regional Economic Development Services Office/Partnerships for Health Reform meeting with PS1, MOHP on 30 June 1998.

provider of services.<sup>4</sup> Reforms and new systems at the central level will need to be compatible with those implemented at the provider level. For reforms and hospital autonomy to be meaningful, the MOHP must demonstrate that the currently large proportion of public expenditure devoted to hospital services is properly spent and that funds are prudently and efficiently allocated. The MOHP needs improved financial management systems. It needs personnel who can control expenditures, critically examine the performance of hospitals, and manage competing claims for resources.

The capacity of the central MOHP Finance Department needs to be assessed. A matching system of control and supervision needs to be introduced to guarantee that increased autonomy and authority is used responsibly, and that the financing mechanisms assure equity and efficiency. The system of resource allocation may need to incorporate contracts based on negotiated cost per case, or weighted cost per case, as opposed to block grants or global allocations. The contract negotiation process requires staff which can manage contracts, costing, and monitoring systems. Block contracts and also cost and volume contracts will need to be managed as part of systems for paying for hospital services. Staff will need skills in financial analysis and financial modeling. They will need skills in cost and management accounting and in the use of financial information for decision making.

Standard financial instructions and a financial manual will be developed for autonomous hospitals and hospital boards. The contents of the annual report and accounts for hospitals will become statutory requirements. Guidance on corporate governance, codes of conduct, and accountability can be drawn up alongside new legislation setting up hospital boards. The format and contents of the hospital annual business plan will need to be specified. The Finance Department will also need to develop reporting formats for monthly financial returns.

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<sup>4</sup>The Hospital Autonomy Working Group proposes the establishment of an Office of the Director of Hospital Services. This office will plan and implement the process of change, manage resource allocation to hospitals, and monitor hospital-based service delivery.

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## 04. Health Care Financing

The assessment of health care financing policy options looks at both: (1) opportunities of increased revenue generation through four different cost sharing mechanism, and (2) better use of existing resources through increased efficiencies. The four approaches to cost-sharing include:

- ▲ user fees;
- ▲ community financing schemes;
- ▲ prepayment or insurance schemes; and
- ▲ the private sector experience.

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### 4.1 User Fees

Both preventive and curative services are provided free of charge in public sector facilities. Tertiary care, ambulance transport, drugs, and in-patient food service are all free. Nevertheless, cost sharing has long been a topic of discussion, and most Malawians typically do pay for their health services. Public hospitals are now authorized to charge for private wards, for fee-based outpatient departments (OPDs), and for specialist services. CHAM facilities, which provide between 30 and 40 percent of facility-based health care in Malawi, have a long tradition of charging for drugs, consultations, and laboratory services. One comprehensive study (Franco et al. 1995), shows that more than half of Malawians already pay for health care. This includes both the rich and poor. In fact, the study shows that the poor may be more likely to pay for health care.<sup>5</sup> The same study also shows that people in Malawi say they are willing to pay for health services—provided the payment is linked to an improved service. The most common improvement mentioned was the availability of drugs. Median monthly household expenditure on outpatient care purchased from CHAM and traditional healers was reported to be eight and seven Kwacha respectively (approximately US\$0.50 at the time of the study). Both of these providers have a long history of charging for services and, presumably, good knowledge of their clients ability to pay. The same study showed that MOHP facilities were the first source of care for only 25 percent of respondents. Overall, when last ill, 75 percent of respondents sought care first at a source where some kind of charge was levied.

Authorization for GOM facilities to charge for services is recent and, for the most part, implementation has been limited to central hospitals. The private inpatient ward in Lilongwe Central Hospital has approximately 30 beds, of which 10 were occupied when we visited. The charge for the private inpatient ward is K250/night, with separate charges for services such as specialist consultations, drugs, and laboratory exams. The fees in OPD#1, the private out-patient ward, are K40 for a consultation with a generalist, and K60 for a consultation with a specialist. The team was unable

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<sup>5</sup>Fifty-seven percent for those characterized as poor vs 53 percent for those categorized as rich.

to determine an average daily volume of patients in OPD#1 but according to staff, the numbers are small. Consequently, charges for private outpatient and inpatient care to date produce scant revenue, even for the central hospitals. Health centers operated by local authorities, such as cities and towns, do charge for drugs and consultations but they are few in number and serve few clients.

The team visited a CHAM hospital at Nkhoma, in a rural area one hour outside of Lilongwe, where fee for service is the norm. According to the administrator, exemptions are given to those truly unable to pay. The estimated level of exemptions is 1–2 clients per month. The hospital more typically issues bills or invoices to those who cannot pay when they receive services. The client is then expected to pay whenever it becomes possible; but no effort is made to collect these charges. The accountant reported that most clients generally return to pay their bill, sometimes after considerable time has elapsed. Fees in CHAM facilities are set by each institution. An attempt was made to make CHAM fees uniform, but this effort was abandoned.

MOHP documents indicate a continuing interest in cost sharing.<sup>6</sup> Authorization to charge for services is understood as essential for hospital autonomy. Service providers seem to appreciate the need to generate additional revenue, and providers interviewed by the team believe the introduction of fees to be feasible. Nevertheless, cost sharing has not become policy. According to several observers, the reasons are largely political rather than technical. Apparently, cost sharing was tried some time ago but the public objected and it was abandoned. Given the past history, policymakers are reluctant to support a policy that might prove unpopular.

**Analysis.** Cost sharing at modest levels is feasible. At a minimum, fees can and should be introduced in tertiary hospitals. A key to success of any cost sharing initiative is ensuring value for money. In Malawi, as in much of the developing world, value means drug availability. Given problems with ensuring drug supply and the importance of drugs in cost sharing, attention should be devoted to Bamako Initiative type schemes where the goal is to fully recover drug costs. Experience in other countries has demonstrated that these schemes can work even in very low income settings.

Cost sharing must be approached in the context of an overall health care financing policy. Bamako Initiative schemes, for example, aim to recover primarily drug costs; anything extra is viewed as a bonus, whereas fees at tertiary hospitals are generally used for other reasons. They may be used to improve the hospital's ability to generate still more resources, or to reinforce the referral chain. Another example, national health insurance schemes, aim to provide coverage for formal sector workers. A comprehensive national health care financing policy would map out a constellation of interventions which would meet commonly defined objectives. The MOHP working group report on health care financing has begun this process; but the current product falls short of being a systematic approach that outlines a comprehensive solution, with well articulated costs and benefits, and specific recommendations.

Timing, institutional constraints, and management capacity merit consideration. Generally, hospital-based curative services are least deserving of public subsidies. Fees should be applied here first. This has the added benefit of creating a financial incentive to respect the referral chain. Since drugs are so crucial to health care outcomes, Bamako Initiatives that recover drug costs are a logical next step. With the appropriate training, both of these initiatives build financial management skills and set the stage for alternative health care financing schemes. Once fees are in place and services must be

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<sup>6</sup>See, for example, MOHP, August 1997b.

purchased, pre-payment and insurance should be considered. Without the “financial threat” of fees, there will be no incentive to enroll in pre-payment or insurance schemes.

Recommendation: Current cost-sharing experience should be documented and disseminated. This documentation process should be followed by the development of a national health care financing policy for Malawi.

Recommendation: Cost-sharing should be expanded at central hospitals and pilot tested at district hospitals.

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## 4.2 Community Financing Schemes

The principal form of community financing has been—and remains—community drug revolving funds operated by community based volunteers. The World Bank PHN Project has been a major supporter of community based drug revolving funds. The penetration and coverage of the funds across Malawi is difficult to determine. The World Bank originally began revolving funds in ten priority districts with plans to go nationwide. The revolving funds provide initial stocks of five common drugs: SP, paracetamol, aspirin, eye and skin ointments. Performance of revolving funds is generally deemed good, as noted in Picazo (1997), which in turn references a World Bank evaluation dated 1996. Conversations with officials in Dowa district indicate that they are having some problems with complete regeneration of the funds. District staff reported a recovery rate of 80 percent for the cost of the drugs in the eight centers where funds were operational. Staff estimated that the revolving funds covered 20–30 percent of the population. District staff indicated that they managed to keep the funds operational by “borrowing” money generated by another revolving fund to replenish the stock for another. This form of pyramid scheme cannot continue indefinitely. Franco-Miller et al. (1995) reviewed the performance of drug revolving funds in Malawi up to 1995. Few of the funds that had been started prior to the evaluation were in existence at the time of writing their report.

**Analysis.** Clearly, community financing of drugs is an attractive proposition for many reasons. They provide community-based treatment for malaria which reduces delays in treatment and can decrease morbidity and mortality. If the fund can be made truly revolving—with sufficient resources generated to meet the cost of replenishing the drugs—then the fund can theoretically continue indefinitely with little need for resupply. The reality is perhaps something less than the ideal, but recommendations should follow from a comprehensive assessment of drug revolving funds. One concern is the inequity of charging for drugs at the community level while providing free health care at health centers. Ideally, it should be the reverse. Curative care should be more expensive than preventive care. Levels of care closest to the client should be the least expensive.

Recommendation: Pending a more thorough assessment, drug revolving funds are deserving of support, though donors should probably expect to continue subsidies for the foreseeable future.

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### 4.3 Pre-Payment and Insurance

Health insurance is rare in Malawi. No national health insurance scheme exists, nor is it likely to exist in the near future. Employment in the formal sector remains very small. No information or examples of community-based forms of health insurance could be found. Nevertheless, insurance coverage does exist for a select segment of society and is provided by the Malawi Medical Aid Society (MMAS). According to most observers, the magnitude is small and restricted to high-income businessmen. It should be noted that Nkhoma Hospital, a CHAM hospital located approximately one hour from Lilongwe, maintained a separate fee schedule for MMAS patients. This fee schedule was considerably higher than those charged to local patients, perhaps equal to full cost recovery prices though we were unable to determine if this was the case.

**Analysis.** As would be expected in an agrarian economy, ability to pay varies considerably across time. Cash is most available when crops are harvested, and is scarcest in the period leading up to harvest. In such a situation, it is reasonable to assume households adjust consumption in response to the availability of cash. In rural settings smoothing consumption is difficult as banks are rare and saving in the form of cash is insecure. If cost sharing for health services is to be introduced, consideration should be given to the potential benefit that pre-paying for health care might afford. By allowing households to pre-pay for a portion, or even the entirety of their health care costs, they may achieve improved and more timely access to services. This has proved very useful and attractive to rural consumers in other countries. The viability of pre-payment and especially, insurance schemes, depends on the imposition of user fees for health care services. There is no incentive to participate in a pre-payment or insurance schemes when services are free.

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### 4.4 The Private Sector and NGOs

As noted in the section above, the private sector accounts for a considerable portion of the health care used by Malawians—over 60 percent according to the USAID-UNICEF 1995 study. The private-sector share of facility-based health care is likely to be smaller (on the order of 40 percent) but still important. Nonetheless, private sector involvement in public health policy making appears minimal. Private sector participation in the planning of health service provision at the district level also appears minimal. The visited CHAM facilities reported that they do not participate in meetings of the district health team. Collaboration is better on “medical” issues. “Outbreaks,” for example, are reported to district management.

In many areas, CHAM facilities are the only ones present. Since CHAM facilities charge— and public facilities do not—this has given rise to political pressure on the MOHP to build public facilities in CHAM catchment areas. This temptation should be avoided. Building new public facilities in areas already served by CHAM is an inefficient use of resources.

**Analysis.** Building and running health care facilities is a costly proposition, and one which most governments do not do particularly well. The MOHP should look for ways to expand access to health care by working with CHAM. Although no data exist to substantiate such a claim, it may be more cost-effective for the MOHP to contract out provision of health services to CHAM rather than build or expand MOHP facilities. Uganda is considering such a relationship.

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## 4.5 Improving Efficient Use of Limited Resources

A fundamental problem with the health sector in Malawi is simply too few resources. The ability to raise additional resources for health—from the government, the public or donors—is undoubtedly limited. Consequently, it is appropriate to consider how more can be done with less.

Students of health economics and health sector reform often explain health systems outcomes by understanding the nature of the incentive structure. The clearest example is the outcome that results from paying providers on a fee for service basis. This explains, for example, much of the rapid rise in health care costs in the United States. When provider payment was based on fee for service, U.S. health care providers had incentives to provide more care, even when it was not necessary. Health care costs soared. When the United States switched to capitation, paying providers a fixed amount per person, health care spending slowed, though patient complaints about under-provision of care increased.

Incentives affect the health system globally, as in the example of provider payment, but they also have a large effect on health service delivery at lower levels. One example is revenue retention. Returning revenues to the central treasury prevents providers from using the money to meet service delivery needs. Providers have little incentive to collect fees since doing so will have little impact on their own ability to provide quality services.

In Malawi, health workers are employed by the MOHP rather than by the hospital or health centers where they work. Immediate supervisors have little role in their performance evaluation. Under the reform initiatives being discussed, district health workers will become district employees while staff at the central hospitals will work under autonomous hospital management. Decentralization reforms would fund district health services via district administration. If hospital autonomy is successful and user fees are introduced in central hospitals, districts could contract with central hospitals for referral care. Forcing central hospitals to adapt to this form of financing would create incentives for efficient use of resources.

Donor funds can be used to demonstrate incentive-based performance contracting. This would assist MOHP headquarters in assuring that districts attend to national priorities. Some examples might include:

*Health status indicators.* Additional supplementary funding can be allocated to districts which demonstrate that they have achieved previously reviewed and approved targets related to family planning, safe motherhood, and child survival.

*Cost-sharing.* Locally generated revenues can be matched to encourage districts to undertake innovative cost-sharing initiatives.

*Program Reforms.* Specific reforms such as delinkage of district health offices from district hospitals can be rewarded with cash grants.

**Recommendation:** Selected performance-based contract methodologies should be tested to determine which serve best in communicating MOHP headquarter priorities to district-level decision-makers.



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## 05. Drug Supply Management

In his March 1997 report to USAID/Malawi, Picazo recommended drug supply management as the single health sector reform activity most likely to produce impact.<sup>7</sup> Interviews and site visits conducted by this assessment team indicate the problem continues to be characterized by the chronic shortages described in earlier reports (for example, Word Bank, 1996). At the time of the visit, for example, Central Medical Stores (CMS) and all of the facilities visited were stocked out of the most commonly used antibiotic. Both of the CHAM hospitals and one of the two government hospitals reported buying from the private sector when CMS was stocked out of a required commodity.

The CMS provides drugs and medical supplies to central hospitals, other MOHP health facilities, CHAM facilities, local authority facilities, and even the private sector providers. CHAM facilities and private sector providers pay cash. Government facilities, both MOHP and local authorities, receive free drugs and medical supplies against a budget allocation. They do not pay from their own budgets. Local authority facilities sell these drugs and return the receipt from these sales to local accounts. Allocation of funds for drugs and medical supplies to MOHP and local government facilities has been first decentralized, then recentralized over the last few years. The decentralization and then recentralization represent attempts to respond to overspending on drugs. Each year, regardless of decentralization or recentralization, district consumption of drugs has exceeded the value budgeted, and CMS has moved further and further into deficit. This problem is aggravated by the declining value of the Kwacha against foreign currency.

Both the Mwambaghi report (1996) and a DfID-funded Deloitte & Touche study recommended that CMS be made autonomous. The Deloitte and Touche study also included three key recommendations:

- ▲ contract CMS functions out to the private sector,
- ▲ eliminate two satellite stores in the two other regions, and
- ▲ downsize staff from the current level of staffing.

Submission of the Deloitte and Touche study was accompanied by an offer from DfID to provide approximately one million pounds sterling to pay off the CMS deficit if the GOM agreed to autonomize CMS and agree to the three key recommendations. The GOM has agreed to pilot test the “contracting out,” to “scale down”—rather than eliminate—two satellite stores in the two other regions, and to reduce staff. Autonomization of CMS, though, seems to have stalled for more than a year now after the MOHP withdrew the proposal from consideration pending clarifications. DfID is continuing to work with the MOHP on responses to these recommendations.

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<sup>7</sup>The report described eleven potential areas of USAID involvement in health sector reform and rated each reform area for its potential impact. Drug supply management was the only area receiving the maximum score of 5.

**Private sector pharmaceutical sources.**<sup>8</sup> Three of the four visited hospitals bought drugs from private pharmaceutical companies in Malawi. One government hospital had access to donor funds which were used to buy from private firms when CMS was stocked out of the required drug. Two of the hospitals report private sector pharmaceutical prices to be less than unit prices at CMS. One related an experience of having ordered a drug from a pharmaceutical company that did not have the drug in stock but was able to bring it from South Africa within the same day. One CHAM facility reports receiving one-third of its drugs from each of the following three sources:

- ▲ one-third in an annual donor-funded shipping container of drugs from International Drug Association (IDA),
- ▲ one-third from CMS with cash from the sale of drugs. This pharmacist reports that CMS typically has a wider range of drugs available,
- ▲ one-third from private pharmaceutical companies in Lilongwe for those items for which the unit cost is less than at CMS.<sup>9</sup>

Stock management practices at the two government facilities were not so bad as they were erratic. For example, both hospitals recorded periodic physical inventories on the tally cards. On the other hand, tally cards show that these facilities—both within an hour of Lilongwe—would sometimes collect nearly a year's supply of one drug while collecting very little of another. Decentralization and/or cost-recovery initiatives will require more precise stock management practices so as not to tie up limited resources.

From a health reform policy perspective, early resolution of these problems is essential for at least the following reasons:

1. Reliable access to drugs and supplies, from the clients' perspective, is perhaps the single most apparent indicator of quality of care. Any attempt at cost-sharing or revenue generation will be compromised if a full range of essential drugs and supplies is not available at the point of service delivery, and
2. Given current systems, deficits currently accruing at CMS will be shifted to districts as management systems are decentralized. Without resolution, these deficits will compromise the financial sustainability of decentralization.

**Recommendation:** Record-keeping, accountability, and stock management procedures should be improved to support more precise budgeting and procurement of drugs and medical supplies.

**Recommendation:** All facilities should be clearly and uniformly authorized to procure drugs and supplies from the private sector when (1) stock-outs occur at CMS and a

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<sup>8</sup>Hospital pharmacists reported having procured from four private sector pharmaceutical companies in Lilongwe: SADM, ESSKAY Pharmaceuticals, Pharmavet, and Pharmanova.

<sup>9</sup>CMS charges cost plus a 12.5 percent markup for their services. This is less than the 20 percent and 17 percent markups which this author has noted at two other government medical stores within the region.

certificate of non-availability has been obtained, or (2) when they can document lower unit costs from the private sector.

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## **06. Human Resources**

Human resource development was listed as a major problem by many informants. A shortage of positions, inadequate training facilities, and poor conditions of service were often listed as causes of concern. Although the team does not underestimate the magnitude of this problem, the team was not able to undertake extensive investigation on this topic. This occurred for two reasons. Other donors, particularly the European Union and DfID are already attending to this issue. Experience with other countries in the region suggests this is not a technical area in which USAID typically works or has a comparative advantage.

Nevertheless, the team would encourage further analytic work to determine the relative importance of causative factors leading to this problem. Such an analysis would support precise, cost-effective interventions.



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## 07. Management Information Systems

Regardless of which form of health reform predominates, decision-making will certainly shift to more local levels. The team finds significant evidence of attention to broadening participation in decision-making and to improved planning processes, but the team has found little evidence of efforts to inform this new level of decision-making with reliable data. Two kinds of data will be necessary: (1) performance data, and (2) financial data. If decentralization is to result in improved performance, local level decision-makers will be expected to apply limited resources to optimal interventions.

**Performance Data.** Health status indicators for Malawi as a nation are indeed worrisome. Population growth rates are estimated to be 3.1 percent. The fertility rate is estimated to be 6.5. Infant mortality is estimated to be 133 deaths per thousand births. Under-five mortality is estimated at 217 deaths per thousand, and the World Health Organization estimates that 60 percent of child deaths could be prevented or treated through primary health care. HIV infection rates are already very high, are expected to double in the next decade, and result in extreme demands on the health delivery system.

Health reform and decentralization must provide vehicles for communicating these national concerns to local decision-makers. Most nationwide survey results can be replicated by simplified surrogate indicators which can be used at the district level to track performance. Local health committees, for example, can track their success in diminishing fertility by monitoring acceptors of modern methods of contraception or “contraceptives issued” converted into couple years of protection. The absolute number of facility-based infant and child deaths can be monitored across time. The financial impact of HIV infection rates can be humanly moderated through the number of families trained in home-based care. The number of women receiving antenatal care can serve, at the local level, as a surrogate measure for success in promoting safe motherhood.

In the current centralized system, the emphasis is on reporting such data up the system to the national level where aggregation and reporting is running years behind. Feedback does not occur, nor is it likely to occur given resource constraints. Site visits during this rapid assessment, plus comments from the *District Health Office Management Audit* (Hageboeck 1998), suggest that source data is being rigorously recorded, but there is painfully little evidence of it being used to assess performance or inform decision-making at any level.

Decentralization of decision-making to local levels provides an opportunity to optimize the use of these surrogate measures in forums that have the ability to respond. In many cases, responses at the local levels close to the point of service provision will generate a more immediate outcome. Districts can monitor the return on their investment through the review of surrogate indicators of community health status.

**Financial data.** Central interventions such as the Medium Term Expenditure Framework and the Cash Management System seem to have provided little if any perceived benefit at the district level. Districts express despair at the lack of relationship between their budget submissions and actual funding for the district level. The erratic and unpredictable district receipt of these funds further frustrates efforts to plan expenditures at the district level.

Hopefully, the ability of districts to plan health expenditures will improve due to:

- ▲ block grants to districts under decentralization,
- ▲ adoption of the “coffee cup” solution using EU other recurrent transactions subsidies to smooth the flow of funds as recommended in the *District Health Office Management Audit*, and
- ▲ increased cost-sharing procedures resulting from clearly communicated authorization of 100 percent retention at district levels.

Improved use of both performance data and financial data will be required if district communities are to assume the roles envisaged by the health reform process.

**Monitoring the Impact of the Health Reform Process.** Anecdotal reports from other countries which have undergone versions of health reform and decentralization do not necessarily indicate an immediate improvement in health status indicators.<sup>10</sup> This is likely due to varying levels of impact achieved by each locality. Central level monitoring will have to be improved to differentiate—in a timely manner—between those districts performing at varying levels. Successful districts should be identified early and their means of achieving impact publicized. Districts demonstrating less success should be provided with remedial technical assistance. Proper management of the health reform process, and documentation of its impact on nationwide health status, will require early preparation of district profiles that assure baseline data on key indicators of health status. The MOHP Health Planning Unit is preparing new guidelines for district profiles; but the district audit questions whether even the new format includes sufficient quantification of performance measures.

**Recommendation:** A simplified set of locally calculated surrogate indicators of key health status measures should be prepared. District health committees should be trained in the use of these indicators.

**Recommendation:** “Coffee cup” suggestions from the *District Health Office Management Audit*, together with block grants, and 100 percent retention authorization should be implemented to assure more predictable financial information.

**Recommendation:** Central level processing methodologies should monitor the impact of health reforms on key health indicators in a sufficiently timely manner to allow for corrective interventions.

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<sup>10</sup>Ghana and the Philippines, for example.

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## 08. Donor Coordination

There are a number of donors (multilateral, bilateral, and private voluntary organizations) that are active in Malawi. Together, external aid to the Malawian health sector amounts to a considerable portion of the total budget. Enhanced donor coordination can help reduce duplication and frame a development agenda for Malawi. Were external assistance to be reduced suddenly, it would severely constrain the delivery of health care services. Increased donor coordination and cooperation is critical to ensuring efficient use of resources as well as to pursuing and promoting a health reform agenda—at the central level as well as at the district level.

USAID co-chairs the health donor working group. UNFPA is the other co-chair and DfID serves as backup. This group has been meeting regularly and provides an opportunity to share lessons as well as to improve coordination. The MOHP has not taken an active lead in coordinating donors. At the district level, experience is mixed with some district health management teams and/or development experience clearinghouses (DEC) taking on a more proactive coordination role. Six district development fund (DDFs) pilot sites have demonstrated increased coordination. These six have adopted processes which bring together all of the key actors as members of the district council's or DEC's health committee.

A number of donors are interested in various components of a health reform strategy. The extent to which donor perspectives and the agenda for health reform are synergistic will determine how well broader coordination can take place and what type of assistance and leverage can be applied to promote reforms. Large discrepancies in donor perspectives, as well as differences with the MOHP, could lead to inaction. Moreover, should reforms proceed without donor and MOHP consensus, implementation is also likely to fail.

Based on interviews and documents reviewed, the following donor summaries are presented:

- ▲ *European Union.* The EU has supported the development of a human resources development plan, the beginning of a health care financing plan, as well as other planning functions at the MOHP. This assistance has included the placement of a health planning advisor in the HPU, as well as the possibility of two more advisors in health planning-related areas, and one advisor for maintenance issues. EU financial support has been used to “top off” the overall MOHP recurrent health sector budget.
- ▲ *DfID.* DfID has been active in supporting CMS reform, the development of the National Health Plan, and in reproductive health policy and programs. In particular, DfID has been very involved in trying to reform the CMS. However, offers to financially assist the CMS to become a parastatal organization failed to win parliamentary approval. In addition, DfID has recently become a proponent for the sector-wide approach.
- ▲ *UNICEF.* UNICEF is involved in a number of activities that have relevance to health sector reform, and participates in the DDF funding format.

- ▲ *UNDP*. The UNDP has been supporting the DDF local government experiment that is serving as the basis for the OPC decentralization proposal. Whereas UNDP is committed to expanding its support (DDF is now going nationwide), their long term budgetary support for such funds is unclear leading to questions regarding sustainability.

Recommendation: USAID should consider the following actions to improve donor coordination in Malawi: (a) assist the central MOHP in maintaining a database on donor activities, funding, and future plans, (b) require USAID grantees to cooperate with their partners (DHMT as well as other donors) at the district level, (c) initiate dialogue within the working group on health reform issues.

Recommendation: It is premature for Malawi to embark on a SWAP. Preconditions are not in place. Financial management and performance monitoring systems must be upgraded. Technical assistance should be provided in both of these areas.

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# Annex A: Financial Management Implementation

This programme consists of three phases. The first phase is concerned with establishing the general ledger accounting systems. This will help to improve financial planning and budgetary control. It will develop the capacity of the financial reporting and accounting systems to measure performance and productivity. The system will consolidate information from all financial feeder systems and measure indicators such as average cost per case and cost per day. The second phase requires a substantial investment in control of assets, safeguarding cash income, and monitoring patient services. This phase is a pre-requisite for routine costing. It provides detailed stores accounting. The third phase will improve resource management. It provides costs by departmental and specialty. Patient services are grouped by common diagnosis and/or treatment. These cost data are used in monitoring and reviewing performance, in comparison between hospitals, for negotiating contract prices, and for determining resource allocation. This task may require the employment of additional specialized accounting staff.

Phase I can be implemented in a pilot hospital within 12 months. This phase will require the provision of technical assistance. The time estimate assumes timely identification of appropriate computer software and delivery of the required equipment. The time required to replicate this work at the second and subsequent hospitals could be much shorter.

Phase II installs rigorous control measures in purchasing and supplies management, inventory control, and management of the pharmacy. This requires full commitment of the hospital management. That commitment must be directed towards achieving gains in terms of economy, efficiency, quality of care, and public accountability. In some cases, substantial capital improvements may be required in physical storage facilities before new systems can become functional. Training may be required for staff inexperienced in these areas. Technical assistance may be needed for up to 12 months at one site.

Phase III requires more involvement from clinicians in resource management, the accumulation of workload/activity data and patient statistics, and much greater interdependence between the component parts of the hospital information system. Although a simplified costing system of the type that can be achieved under Phase I will support resource allocations using global financing or block grants, a more detailed system is required to negotiate government contracts. Such contracts typically involve payment for specific cases or case mix. These contracts set prices for private fee-paying patients. A step down costing approach can be used to produce periodic information. Annual information will support budgeting and business planning. The more detailed costing work and the financial modeling for contract or budgeted activity could be contracted out at least initially.

A typical systems development and implementation program (covering accounting, purchasing, supplies and stock control) is listed below. This would apply to a central hospital which already maintains public sector cash accounting records.

Phase I:

- i. Introduce general ledger accounting systems which combine the nominal ledger and the creditors and debtors ledgers. Initially the system can be set up to operate in accordance with the government cash accounting system and then converted to accounting on an accruals basis when full financial autonomy is granted.
- ii. Design matching budget ledgers for budgetary control statements and to provide a feedback control system, and optionally implement a system of flexible budgeting which reflects the level of hospital activity.
- iii. Produce automated financial forecasts based on actual performance to provide a feed-forward control system.
- iv. Identify and allocate staff costs by department and include the staff salaries and allowances (and staff numbers) in regular financial reporting and budgeting (even if pay continues to be centrally processed in the interim period before the hospital takes over responsibility for the payroll). This work can be undertaken as part of the programme of transferring personnel records to the hospital.
- v. Maintain separate departmental accounts for outpatient services and operate a system of journals that allocate direct staff costs and other recurrent expenditure items to the OPD. These journals can usually be set up for automatic reversal after month end reporting in order to preserve the accounts records in a form that will be acceptable for government accounting in the short term.
- vi. Incorporate hospital activity data as statistical accounts in the general ledger and include hospital level cost reports in the routine monthly financial reporting which show overall cost per day and cost per case for inpatients and cost per visit for OPD and other clinic attendances.
- vii. For management accounting and performance monitoring, organize the hospital into departmental cost centers and begin the process of allocating direct costs to each of the departments (general services, paramedical, medical and nursing). Develop a chart of accounts and introduce analysis codes to produce departmental budgetary control reports, and departmental costs as well as functional line item expenditure analysis.
- viii. Establish output measures for all cost centers to serve as the denominators for the main financial performance indicators.

Phase II:

- i. Reorganize stores and introduce a system of coding and stores accounting that values all stock items for balance sheet accounts. Computerize the inventory control systems and automate all routine reporting—inventory balances, inventory cover, stock takes, etc., and particularly the analysis and costing of stock issues by cost center.

- ii. Evaluate the possibility of introducing specialized inventory control and dispensing systems for the pharmacy.
- iii. Implement a comprehensive purchase order processing and purchase invoice system that integrates with the inventory control system and updates stock balances. Optionally introduce a system of commitment accounting to improve expenditure control.
- iv. Improve the control and accounting for cash invoices by replacing the manual receipt system with cash registers at all revenue collecting points.
- v. Develop the cash register/epos system to produce sales history and sales analysis reports to support the hospital information system and to control treatment services.
- vi. Commence system development that will integrate the patient accounting and invoicing systems with the patient administration and management systems.

Phase III:

- I. Introduce specialty costing to produce the average cost of treating patients within a specialty in order to provide better information for performance evaluation and decision-making. The initial costs can include only the expenditure on patient treatment services with general services and overhead expenditures held as a separate figures.
- ii. Fixed assets accounting and depreciation charges to be included in financial statements and service costing.
- iii. Move to full specialty costing including the apportionment of all general overheads in order to produce a more comprehensive cost for each specialty and support services costs to provide figures that would be comparable with viable private sector services.
- iv. Evaluate the opportunities and economies for contracting out of services using current internal cost information and assess capacity for preparing contract documentation and contract management.
- v. Selective contracting out of services to the private sector where there are demonstrable cost savings in buying out these services.
- vi. Design and implement a suitable contract, costing, and monitoring system in order to negotiate contract prices for services with MOHP (and district health/hospital boards).
- vii. Develop standards costs, and establish the capacity for variance analysis and the modeling of contract activity to produce prices for a range of contract activity.



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